BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

DARRELL J. JESSOP, M.D.

Holder of License No. **23441**
For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-06-0047A

FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on April 11, 2007. Darrell J. Jessop, M.D., ("Respondent") appeared before the Board without legal counsel for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 23441 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-06-0047A after receiving a complaint regarding Respondent's care and treatment of a twenty-eight year-old male patient ("JP"). JP presented to Respondent on May 13, 2002. Respondent treated JP for a diagnosis of lumbar radiculopathy, with MRI findings of a small L5-S1 annular tear and minimal associated disc protrusion, by prescribing sustained release opioid (Oxycontin) 80 mg q 12 hours, Percocet for breakthrough pain, and Robaxin. Respondent and JP entered a pain management contract. On May 20, 2002 Respondent noted JP had persistent pain and daytime somnolence and insomnia. Respondent added Metadate 20 mg qam to increase JP's daytime wakefulness, increased the Oxycontin dosage by 50 per cent to 120 mg bid, added Temazepam 30 mg qhs for insomnia, and

replaced Robaxin with Zanaflex. On June 12, 2002 Respondent noted his and JP's decision to "get a little more aggressive with the medication." Respondent doubled the Oxycontin from 120 mg bid to 240 mg bid, added Valium as a muscle relaxant at 10-20mg tid prn, and increased the Oxycodone to 5mg 5-6 tablets q four hours prn breakthrough pain.

4. On July 11, 2002 Respondent's increased JP's Oxycontin from 240 mg bid to 240 mg tid, added Diazepam 10 mg two tid, and increased the Oxycodone 5mg 5-6 tablets q four hours prn breakthrough pain to 7-8 tabs q four hours. When JP returned to Respondent's office on July 18, 2002 Respondent noted his slight slurred speech, slight ataxia, and that he was nodding off at work. Respondent's chart entry notes "probably too rapid and large titration of Oxycontin." Respondent recommended the Oxycontin be decreased, continued Oxycodone 5 mg 7-8 tablets q four hours prn, and increased the Diazepam to 10 mg 2-3 po tid-qid. On July 23, 2002 JP reported by telephone that he blacked out and was concerned about the problems with weakness in the knees and slurred speech. Respondent advised JP to decrease the nighttime dose of Valium and increased the Metadate to 60 mg qd. In August 2002 Respondent recommended JP consult with a pain management specialist. On August 20, 2002 Respondent documented a discussion with JP about the pros and cons of invasive treatment and JP's wish to defer such procedures.

5. Ultimately Respondent stabilized JP's medication regime and on monthly follow-up for the period of August 2002 through August 2003 the dosages remained stable with JP reporting effective, though incomplete, pain relief, good function, and absence of side effects. Respondent noted his absence of suspicion of diversion. JP's medications were Oxycontin 240 mg tid, Oxycodone 5 mg 7-8 tablets q four hours prn breakthrough pain, Diazepam 10 mg q four hours prn generalized anxiety, and Metadate CD 60 mg daily. Because of insurance delays JP did not consult with a pain specialist until December 19, 2002. The pain specialist diagnosed lumbar discogenic back pain, opined that the medications prescribed by Respondent were

appropriate, and documented a long discussion with JP regarding invasive techniques, including translaminar ESI, transforaminal ESI, discography and IDET. On January 7, 2003 Respondent again documented a discussion with JP about the pros and cons of invasive treatment and JP's wish to defer such procedures. Respondent continued his monthly follow-up of JP, the medication dosages remained stable, and JP had no significant change in symptoms.

6. On August 19, 2003 Respondent saw JP in follow-up. JP presented with a new problem of neuralgic pain in a thoracic dermatome. Respondent diagnosed Herpes Zoster, although vesicles had not yet appeared, and added Hydromorphone for this new pain. One week later JP reported the Hydromorphone was ineffective and Respondent added Demerol 50 mg po tid prn and warned JP of the problems associated with active metabolites. JP returned to Respondent on September 18, 2003 and did have a thoracic dermatomal vesicular rash consistent with Herpes Zoster. Respondent prescribed anti-viral medication and Medrol dose pack. On October 21, 2003 JP presented to Respondent in moderate distress and reported 10/10 pain. Respondent added Methadone 40 mg bid and Zonegram 100 mg qhs for post-herpetic neuralgia. Respondent doubled JP's Effexor XR to 150 mg per day. Respondent's documented rationale for adding Methadone was to "augment the effect of Oxycontin." Under "assessment" Respondent wrote "medication warning not required."

7. JP presented to Respondent on October 22, 2003 with somnolence, confusion, slow speech, and sluggish pupils. Respondent immediately realized JP's Methadone usage was too high, administered 1 cc Naloxone in his office and sent JP home thirty-five minutes later with instructions to taper down to Methadone 10 mg bid beginning the next day. Respondent saw JP in follow-up on October 23, 2003 and noted he was more alert, but still complaining of severe pain. On October 24, 2003 JP returned 55 Methadone 40 mg tablets to Respondent's office. On October 31, 2003 JP underwent inpatient opioid detoxification and epidural injection under the care of his primary care physician. JP was much improved and remains so to date.

8. Respondent is a family practice physician in Tucson and sees a significant population of chronic pain patients, the majority of which are nonmalignant or non-cancer type. According to Respondent, as a primary care physician, he will continue to be the focus of medical pain management for his patients and that medical education for family practitioners has not prepared them for this aspect of medical practice and the majority of family practitioners are learning as they proceed with each patient. Respondent acknowledged he will make mistakes, but not from incompetence or lack of caring, but from not knowing where to obtain information.

9. Ten percent or less of Respondent's pain management patients are at the same narcotic level that JP was and JP is not the typical pain patient he sees. A physician prescribing a medication should be familiar with its dosing regimen, its indications, and its common and more serious side effects and interactions. Regardless of the specialty of a physician prescribing a medication the physician is held to the same standard of care regarding dosing, indications, common and more serious side effects and interactions.

10. In 2002 – 2003 Respondent prescribed Methadone two to five times per year without having full knowledge of properties, dosing, and interactions of Methadone. Respondent was aware of the prolonged half-life and some of the problems inherent in the titration of Methadone, but was not fully aware of the impact of opioids already being taken by JP with the addition of methadone to the regimen.

11. JP originally presented to Respondent with complaints of low back pain and, after MRI, JP's diagnosis was degenerative disc disease. Respondent's physical examination of JP was essentially non-focal and JP's pain was localized, but he did have occasional pain that spread into his buttocks and legs. Respondent's objective findings were that JP's deep tendon reflexes were equivocal, there was no evidence of overt sensory or motor deficits. Respondent's examination was primarily a subjective assessment of JP's pain. Respondent was treating JP for his subjective complaints and had no objective findings. Respondent's goal is to treat the patient's

findings, but when he has no immediate findings by MRI or other evaluation and the patient is reporting severe pain, Respondent believes that pain must be treated. Respondent did not try muscle relaxants, physical therapy or other treatment modalities before embarking on the aggressive narcotic treatment because he believed aggressive treatment was required. Although a physician must listen to a patient's complaints of pain, the physician must examine the patient and reach a clinical diagnosis. Respondent's objective examination and findings in JP did not lead to a diagnosis of any notable problems. Respondent's records contain no etiology for a diagnostic reasoning for prescribing the heavy doses of medication to JP.

12. Because the potency of Methadone increases in the setting of other chronic high dose opioids the standard of care requires a physician not treat acute pain with high dose Methadone when the patient is taking benzodiazepine and high dosage Oxycontin. The standard of care requires initiation of Methadone at a lower dose that is titrated up to achieve the desired effect.

13. Respondent deviated from the standard of care when he initiated Methadone at 40 mg bid in addition to placing JP on benzodiazepines and a high dosage of Oxycontin rather than initiating Methadone at a lower dose and titrating it up to achieve the desired effect.

14. The standard of care for a Methadone overdose requires the patient be admitted to a monitored environment.

15. Respondent deviated from the standard of care because when JP presented with Methadone overdose he observed JP in his office for thirty-five minutes and then discharged him home.

16. JP's Methadone overdose resulted in somnolence and confusion requiring IM Naloxone. JP's Methadone overdose could have resulted in aspiration, coma, respiratory failure, brain damage, or death.

CONCLUSIONS OF LAW

1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.

3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public"); and A.R.S. § 32-1401(27)(ll) ("[c]onduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.").

ORDER

Based upon the foregoing Findings of Fact and Conclusions of Law,

IT IS HEREBY ORDERED:

1. Respondent is issued a Letter of Reprimand for improper Methadone dosing and improper management of accidental opiate overdose.

2. Respondent is placed on probation for one year with the following terms and conditions:

a. Within six months Respondent shall obtain 10 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in pain management, including diagnosis and treatment. Respondent shall provide Board Staff with satisfactory proof of attendance. The CME hours shall be in addition to the hours required for biennial renewal of medical license.

b. Following Respondent's completion of the CME Board Staff shall conduct random chart reviews to ensure Respondent applies the CME to his treatment of patients. The Board may take additional disciplinary or remedial action based upon the chart review.

c. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

d. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this 8th day of June 2007.

THE ARIZONA MEDICAL BOARD

By _____
TIMOTHY C. MILLER, J.D.
Executive Director

ORIGINAL of the foregoing filed this 8th day of June, 2007 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing mailed by U.S. Mail this 8th day of June, 2007, to:

Darrell J. Jessop, M.D.
Address of Record